HOUSE DOCKET, NO. 94915 FILED ON: 7/21/2010

HOUSE . . . . . No. 4915

The Commonwealth of Massachusetts

By Mr. Murphy of Burlington, for the committee on Ways and Means, that the Senate Bill to promote cost containment, transparency and efficiency in the provision of quality health insurance for individuals and small businesses (Senate, No. 2447) ought to pass with an amendment striking out all after the enacting clause and inserting in place thereof the text of House document numbered 4915. July 21, 2010.

FOR THE COMMITTEE:

NAME:	DISTRICT/ADDRESS:
Charles Murphy	21st Middlesex

The Commonwealth of Massachusetts

In the Year Two Thousand and Ten

The Committee on Ways and Means recommends that the bill be amended by striking out all after the enacting clause and inserting in place thereof the following:

"SECTION 1. Section 38C of chapter 3 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following subsection:-

(e) The division of health care finance and policy shall issue a comprehensive report at least once every 4 years on the cost and public health impact of all existing mandated benefits. In conjunction with this review, the division shall consult with the department of public health and the University of Massachusetts Medical School in a clinical review of all mandated benefits to ensure that all mandated benefits continue to conform to existing standards of care in terms of clinical appropriateness or evidence-based medicine. The division may file legislation that would amend or repeal existing mandated benefits that no longer meet these standards.

SECTION 2. Section 16K of chapter 6A of the General Laws is hereby amended by striking out subsections (a) to (c), inclusive, as so appearing, and inserting in place thereof the following 3 subsections:-

(a) There shall be established a health care quality and cost council, which shall be an independent public entity not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency or political subdivision of the commonwealth. The council shall promote public transparency of the quality and cost of health care in the commonwealth, and shall seek to support the long term sustainability of health care reform in the commonwealth by developing recommendations for containing health care costs, while facilitating access to information on health care quality improvement efforts. The council shall disseminate health care quality and cost data to consumers, health care providers and insurers through a consumer health information website under subsections (e) and (g); establish cost containment goals under subsection (h); and coordinate ongoing quality improvement initiatives under subsection (i).

(b) The council shall consist of 18 members and shall be comprised of: (1) 9 ex-officio members, including the secretary of health and human services, the secretary of administration and finance, the state auditor, the inspector general, the attorney general, the commissioner of insurance, the commissioner of health care finance and policy, the commissioner of public health and the executive director of the group insurance commission, or their designees; and (2) 9 representatives of nongovernmental organizations to be appointed by the governor, 1 of whom shall be a representative of a health care quality improvement organization recognized by the federal Centers for Medicare and Medicaid Services, 1 of whom shall be a representative of the Institute for Healthcare Improvement recommended by the organization's board of directors, 1 of whom shall be a representative of the Massachusetts chapter of the National Association of Insurance and Financial Advisors, 1 of whom shall be a representative of the Massachusetts Association of Health Underwriters, Inc., 1 of whom shall be a representative of the Massachusetts Medicaid Policy Institute, Inc., 1 of whom shall be a expert in health care policy from a foundation or academic institution, 1 of whom shall be a representative of a non-governmental purchaser of health insurance, 1 of whom shall be an organization representing the interests of small businesses with fewer than 50 employees and 1 of whom shall be an organization representing the interests of large businesses with 50 or more employees. At least 1 member of the council shall be a clinician licensed to practice in the commonwealth. Members of the council shall vote annually to elect a chair and an executive committee, which shall consist of 4 council members and the chair. The executive committee shall meet as required to fulfill the mission of the council. Members of the council shall be appointed for terms of 3 years and shall serve until the term is completed or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation, but may be reimbursed for actual and necessary expenses reasonably incurred in the performance of their duties which may include reimbursement for reasonable travel and living expenses while engaged in council business. All council members shall be subject to chapter 268A; provided, however, that the council may purchase from, sell to, borrow from, contract with or otherwise deal with any organization in which any council member is in anyway interested or involved; provided further that such interest or involvement shall be disclosed in advance to the council and recorded in the minutes of the proceedings of the council; and provided further, that no council member having such interest or involvement may participate in any decision relating to such organization.

(c) All meetings of the council shall comply with chapter 30A. The council may, subject to chapter 30B and subject to appropriation, procure equipment, office space, goods and services.

The executive office of health and human services may provide staff and administrative support as requested by the council; provided, however, that all work completed by the executive office of health and human services shall be subject to approval by the council . The council shall appoint an executive director to oversee the operation and maintenance of the website, ensure compliance with the requirements of this section, and coordinate work completed by the executive office of health and human

services and may, subject to appropriation, employ such additional staff or consultants as it deems necessary.

The council shall promulgate rules and regulations and may adopt by-laws necessary for the administration and enforcement of this section.

SECTION 3. Said section 16K of said chapter 6A is further amended by striking out subsections (h) and (i), as so appearing, and inserting in place thereof the following 2 subsections:-

(h) The council, in consultation with its advisory committee, shall develop annual health care cost containment goals. The goals shall be designed to promote affordable, high-quality, safe, effective, timely, efficient, equitable and patient centered health care. The council shall also establish goals that are intended to reduce health care disparities in racial, ethnic and disabled communities. In establishing cost containment goals, the council shall utilize claims data collected from carriers under this section, and information gathered as part of the division of health care finance and policy's public hearings on health care costs under section 6 ½ of chapter 118G. For each goal, the council shall identify: the parties that will be impacted; the agencies, departments, boards or councils of the commonwealth responsible for overseeing and implementing the goal; the steps needed to achieve the goal; the projected costs associated with implementing the goal; and the potential cost savings, both short and long-term, attributable to the goal. The council may recommend legislation or regulatory changes to achieve these goals. The council shall publish a report on the progress towards achieving the costs containment goals.

(i) The council, in consultation with its advisory committee, shall coordinate and compile data on quality improvement programs conducted by state agencies and public and private health care organizations. The council shall consider programs designed to: improve patient safety in all settings of care; reduce preventable hospital readmissions; prevent the occurrence of and improve the treatment and coordination of care for chronic diseases; and reduce variations in care. The council shall compile information on programs conducted by state agencies and public and private health care organizations and make such information available on the council's consumer health information website. The council may recommend legislation or regulatory changes as needed to further implement quality improvement initiatives.

SECTION 4. Section 35 of Chapter 10 of the General Laws is hereby amended by inserting after section 35NN the following section:-

Section 35MM. There shall be established upon the books of the commonwealth a separate fund to be known as the Disproportionate Share Hospital Trust Fund, consisting of revenues received under the provisions of section 5A of chapter 176O. The fund shall be used solely for the purposes described in subsection (e) of said section 5A of said chapter 176O. No expenditure from the fund shall cause the fund

to be in deficiency at the close of a fiscal year. Monies deposited in the fund that are unexpended at the end of the fiscal year shall not revert to the General Fund and shall be available for expenditure in the subsequent fiscal year.

SECTION 5. Chapter 12 of the General Laws is hereby amended by inserting after section 11L the following section:-

Section 11M. (a) The attorney general shall have jurisdiction to review all applications for determination of need filed pursuant to section 25C of chapter 111. Following initial approval by the department of public health, all determination of need applications shall be sent to the office of the attorney general for review and approval.

(b) The attorney general shall approve a project only if the attorney general determines that the project will not have an adverse effect on competition in the health care market and shall give due consideration to whether the project is likely to increase rates of payment to providers and whether the project is likely to result in an inappropriate increase in utilization of health care services.

(c) The attorney general shall report to the department of public health the results of said review no later than 4 months after receiving the application from the department. No project shall be approved by the department of public health without approval of the attorney general.

SECTION 6. Section 25C of chapter 111 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by striking the first paragraph and inserting in place thereof the following paragraph:-

Section 25C. Notwithstanding any general or special law to the contrary, except as provided in section 25C½, no person or agency of the commonwealth or any political subdivision thereof shall make substantial capital expenditures for construction of a health care facility or substantially change the service of such facility unless, after review and approval by the attorney general pursuant to section 11M of chapter 12, there is a determination by the department that there is a need therefore,. No such determination of need shall be required for a substantial capital expenditure for construction or a substantial change in service which shall be related solely to the conduct of research in the basic biomedical or applied medical research areas, and shall at no time result in an increase in the clinical bed capacity or outpatient load capacity of a health care facility, and shall at no time be included within or cause an increase in the gross patient service revenue of a facility for health care services, supplies and accommodations, as such revenue shall be defined from time to time in accordance with section 31 of chapter 6A.

A person undertaking an expenditure related solely to such research which shall exceed or may reasonably be regarded as likely to exceed $150,000 or undertaking a change in service solely related to

such research, shall give written notice thereof to the department and the division of health care finance and policy at least 60 days before undertaking such expenditure or change in service. The notice shall state that such expenditure or change shall be related solely to the conduct of research in the basic biomedical or applied medical research areas, and shall at no time be included within or result in any increase in the clinical bed capacity or outpatient load capacity of a facility, and shall at no time cause an increase in the gross patient service revenue, as defined in accordance with said section 31 of said chapter 6A, of a facility for health care services, supplies and accommodations. A determination of need shall be required for an expenditure or change if the notice required by this section is not filed in accordance with the requirements of this section, or if the department finds, within 60 days after receipt of notice, that such expenditure or change will not be related solely to research in the basic biomedical or applied medical research areas, will result in an increase in the clinical bed capacity or outpatient load capacity of a facility or will be included within or cause an increase in the gross patient service revenues of a facility. A research exemption granted under the provisions of this section shall not be deemed to be as evidence of need in any determination of need proceeding.

SECTION 7.Chapter 111 of the General Laws is hereby amended by inserting after section 25O the following section:-

Section 25P. Every health care provider, including those licensed under chapter 112, shall track and report quality information at least annually under regulations promulgated by the department.

SECTION 8. Section 217 of said chapter 111, as appearing in the 2008 Official Edition, is hereby amended by striking out the word ‘plans.’, in line 33, and inserting in place thereof the following words:–

plans; and

(7) administer and grant enrollment waivers under paragraph (4) of subsection (a) of section 4 of chapter 176J; provided, however, that the office of patient protection may grant a waiver to an eligible individual who certifies, under penalty of perjury, that such individual did not intentionally forego enrollment into coverage for which the individual is eligible and that is at least actuarially equivalent to minimum creditable coverage; and provided further, that the office shall establish by regulation standards and procedures for enrollment waivers.

SECTION 9. Section 1 of chapter 118G of the General Laws, as so appearing, is hereby amended by inserting after the definition of ‘Health maintenance organization’ the following definition:-

‘Health status adjusted total medical expenses’, the total cost of care for the patient population associated with a provider group based on allowed claims for all categories of medical expenses and all non-claims

related payments to providers, adjusted by health status, and expressed on a per member per month basis, as calculated under section 6 and the regulations promulgated by the commissioner.

SECTION 10. Said section 1 of said chapter 118G, as so appearing, is hereby further amended by inserting after the definition of ‘Purchaser’ the following definition:-

‘Relative prices’, the contractually negotiated amounts paid to providers by each private and public carrier for health care services, including non-claims related payments and expressed in the aggregate relative to the payer’s network-wide average amount paid to providers, as calculated under section 6 and regulations promulgated by the commissioner.

SECTION 11. Section 6 of said chapter 118G, as so appearing, is hereby amended by inserting after the first paragraph, the following paragraph:-

Providers shall submit to the division medical record information, including but not limited to, case-specific diagnostic data about each medical visit or admission, socio-demographic characteristics, the medical reason for the visit or admission, the treatment and services provided to the patient and the duration and status of the patient's stay or visit, as specified in regulation.

SECTION 12. Said section 6 of said chapter 118G is hereby further amended by striking out the fourth and fifth paragraphs, as so appearing, and inserting in place thereof the following 4 paragraphs: -

The division shall require the submission of data and other information from each private health care payer offering small or large group health plans including, without limitation: (i) average annual individual and family plan premiums for each payer’s most popular plans for a representative range of group sizes, as further determined in regulations, and average annual individual and family plan premiums for the lowest cost plan in each group size that meet the minimum standards and guidelines established by the division of insurance under section 8H of chapter 26; (ii) information concerning the actuarial assumptions that underlie the premiums for each plan; (iii) summaries of the plan designs for each plan; (iv) information concerning the medical and administrative expenses, including medical loss ratios for each plan, using a uniform methodology; (v) information concerning the payer’s current level of reserves and surpluses; (vi) information on provider payment methods and levels; (vii) health status adjusted total medical expenses by provider group, local practice group and zip code calculated according to a uniform methodology; and (viii) relative prices paid to every hospital, physician group, ambulatory surgical center, freestanding imaging center, mental health facility, rehabilitation facility, skilled nursing facility and home health provider in the payer’s network, by type of provider and calculated according to a uniform methodology.

The division shall require the submission of data and other information from public health care payers including, without limitation: (i) average premium rates for health insurance plans offered by public payers and information concerning the actuarial assumptions that underlie these premiums; (ii) average annual per member per month payments for enrollees in MassHealth primary care clinician and fee for service programs; (iii) summaries of plan designs for each plan or program; (iv) information concerning the medical and administrative expenses, including medical loss ratios for each plan or program; (v) where appropriate, information concerning the payer's current level of reserves and surpluses; (vi) information on provider payment methods and levels, including information concerning payment levels to each hospital for the 25 most common medical procedures provided to enrollees in these programs, in a form that allows payment comparisons between Medicaid programs and managed care organizations under contract to the office of Medicaid; (vii) health status adjusted total medical expenses by provider group, local practice group and zip code calculated according to a uniform methodology; and (viii) relative prices paid to every hospital, physician group, ambulatory surgical center, freestanding imaging center, mental health facility, rehabilitation facility, skilled nursing facility and home health provider in the payer's network, by type of provider and calculated according to a uniform methodology.

The division shall require the submission of data and other such information from each acute care hospital on hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform methodology.

The division shall publicly report and place on its website information on health status adjusted total medical expenses, relative prices and hospital inpatient and outpatient costs, including direct and indirect costs under this section on an annual basis; provided, that at least 10 days prior to the public posting or reporting of provider specific information the affected provider shall be provided the information for review. The division shall coordinate with Centers for Medicare and Medicaid Services to determine if Centers for Medicare and Medicaid Services can provide the health status adjusted total medical expenses of provider groups that serve Medicare patients.

SECTION 13. Section 6C of said chapter 118G is hereby amended by striking out subsection (c), as amended by section 9 of chapter 65 of the acts of 2009, and inserting in place thereof the following subsection:-

(c) Information that indentifies individual employees by name or health insurance status shall not be a public record; provided, however, that this information shall be exchanged with the department of revenue, the commonwealth health insurance connector authority, and the health care access bureau in the division of insurance under an interagency services agreement for the purposes of enforcing this section, sections 3, 6B and 18B of chapter 118H and sections 3 to 7, inclusive, of chapter 176Q. Nothing in this section shall prevent the implementation of section 304 of chapter 149 of the acts of 2004. An employer

who knowingly falsifies or fails to file with the division any information required by this section or by any regulation promulgated by the division shall be punished by a fine of not less than $1,000 nor more than $5,000.

SECTION 14. Section 3 of chapter 175H of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting before the word ‘Any’, in line 1, the following:- (a).

SECTION 15. Said section 3 of said chapter 175H, as so appearing, is hereby further amended by inserting after word ‘rebate’, in line 7, the following words:- except as provided in subsection (b),.

SECTION 16. Said section 3 of said chapter 175H, as so appearing, is hereby further amended by adding the following subsection:-

(b) This section shall not apply to a discount, rebate, product voucher or other reduction in an individual’s out-of-pocket expenses, including co-payments and deductibles on a prescription drug, biologic or vaccine provided by a pharmaceutical manufacturing company, as defined in section 1 of chapter 111N, that is made available to an individual if the discount, rebate, product voucher or other reduction is provided directly or electronically to the individual or through a point of sale or mail-in rebate, or through similar means; provided, however, that a pharmaceutical manufacturing company shall not exclude nor favor any pharmacy in the redemption of such discount, rebate, product voucher or other expense reduction offer to an individual.

This subsection shall not: (i) restrict a pharmaceutical manufacturing company with regard to how it distributes a prescription drug, biologic or vaccine; or (ii) restrict a carrier or a health maintenance organization, as defined in section 1 of chapter 118G, with regard to how its plan design will treat such discounts, rebates, product voucher or other reduction in out-of-pocket expenses.

For purposes of the federal Health Insurance Portability and Accountability Act of 1996, hereinafter HIPAA, and regulations promulgated under HIPAA, nothing in this subsection shall be deemed to require or allow the use or disclosure of health information in any manner that does not otherwise comply with HIPAA or regulations promulgated under HIPAA.

SECTION 17. Section 3 of chapter 176D of the General Laws, as so appearing, is hereby amended by striking out clause (4) and inserting in place thereof the following clause:-

(4) Boycott, coercion and intimidation: (a) entering into an agreement to commit, or by a concerted action committing, an act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance; (b) a refusal by a nonprofit hospital service corporation, medical service corporation, insurance or health maintenance organization to negotiate, contract or affiliate with a health care facility or provider because of such facility’s or provider’s

contracts, type of provider licensure or affiliations with another nonprofit hospital service corporation, medical service corporation, insurance company or health maintenance organization; or (c) a nonprofit hospital service corporation, medical service corporation, insurance company or health maintenance organization establishing the price to be paid to a health care facility or provider by reference to the price paid, or the average of prices paid, to such facility or provider under a contract or contracts with another nonprofit hospital service corporation, medical service corporation, insurance company, health maintenance organization or preferred provider arrangement.

SECTION 18. Said chapter 176D, as so appearing, is hereby amended by striking out section 3A and inserting in place thereof the following section:-

Section 3A. The following shall be unfair methods of competition and unfair or deceptive acts or practices in the business of insurance by entities organized under chapters 176A, 176B, 176G and 176I or licensed under chapter 175: (i) entering into an agreement to commit or by a concerted action committing an act of, boycott, coercion, intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance; (ii) refusal to enter into a contract with a health care facility on the basis of the facility's religious affiliation; (iii) seeking to set the price to be paid to a health care facility or provider by reference to the price paid, or the average of prices paid, to that health care facility or provider under a contract or contracts with another nonprofit hospital service corporation, medical service corporation, insurance company, health maintenance organization or preferred provider arrangement; (iv) refusal to contract or affiliate with a health care facility solely because the facility does not provide a specific service or range of services; (v) selecting or contracting with a health care facility or provider not based primarily on cost, availability and quality of covered services; (vi) refusal to enter into a contract with a health care facility solely on the basis of the facility's governmental affiliation; (vii) arranging for an individual employee to apply for individual health insurance coverage, as defined in chapter 176J, for the purpose of separating that employee from group health insurance coverage to reduce costs for an employer sponsored health plan provided in connection with the employee's employment.

SECTION 19. Said Chapter 176D is hereby amended by inserting after section 3B the following new section:-

Section 3C. (a) As used in this section the following words shall, unless the context clearly requires otherwise, have the following meanings:-

'Ambulance service provider', a person or entity licensed by the department of public health under section 6 of chapter 111C to establish or maintain an ambulance service.

'Ambulance services', 1 or more of the services that an ambulance service provider is authorized to render under its ambulance service license.

‘Insurance policy’ or ‘insurance contract’, a contract of insurance, motor vehicle insurance, indemnity, medical or hospital service, dental or optometric, suretyship or annuity issued, proposed for issuance or intended for issuance by an insurer.

‘Insured’, an individual entitled to ambulance services benefits under an insurance policy or insurance contract.

‘Insurer’, a person as defined in section 1 of chapter 176D; a health maintenance organization as defined in section 1 of chapter 176G; a non-profit hospital service corporation organized under chapter 176A; an organization as defined in section 1 of chapter 111I that participates in a preferred provider arrangement also as defined in said section 1 of said chapter 111I; a carrier offering a small group health insurance plan under chapter 176J; a company as defined in section 1 chapter 175; an employee benefit trust; a self-insurance plan; and a company certified under section 34A of chapter 90 and authorized to issue a policy of motor vehicle liability insurance under section 113A of chapter 175 that provides insurance for the expense of medical coverage.

(b) Notwithstanding any general or special law to the contrary, in any instance in which an ambulance service provider provides an ambulance service to an insured but is not an ambulance service provider under contract to the insurer maintaining or providing the insured’s insurance policy or insurance contract, the insurer maintaining or providing such insurance policy or insurance contract shall pay the ambulance service provider directly and promptly for the ambulance service rendered to the insured. Such payment shall be made to the ambulance service provider notwithstanding that the insured’s insurance policy or insurance contract contains a prohibition against the insured assigning benefits thereunder so long as the insured executes an assignment of benefits to the ambulance service provider and such payment shall be made to the ambulance service provider in the event that an insured is either incapable or unable as a practical matter to execute an assignment of benefits under an insurance policy or insurance contract pursuant to which an assignment of benefits is not prohibited, or in connection with an insurance policy or insurance contract that contains a prohibition against such assignment of benefits. An ambulance service provider shall not be considered to have been paid for an ambulance service rendered to an insured, if the insurer makes payment for the ambulance service to the insured. An ambulance service provider shall have a right of action against an insurer that fails to make a payment to it pursuant to this subsection.

SECTION 20. Section 1 of chapter 176J of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting after the definition of ‘Date of enrollment’ the following 2 definitions:-

‘Direct claims incurred’, medical claims paid during an applicable 12-month period which pertain only to that specific period, plus any reasonable unpaid claim reserve.

‘Direct premiums earned’, premiums earned during an applicable 12-month period plus the unearned premiums at the beginning of the period less the unearned premiums at the end of the period.

SECTION 21. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out the definition of ‘Eligible individual’ and inserting in place thereof the following definition:-

‘Eligible individual’, an individual who is a resident of the commonwealth and who is not seeking individual coverage to replace an employer-sponsored health plan for which the individual is eligible and which provides coverage that is at least actuarially equivalent to minimum creditable coverage.

SECTION 22. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the definition of ‘Mandated benefit’ the following definition:-

‘Medical loss ratio’, the ratio of direct claims incurred and other allowable expenses to direct premiums earned, expressed as a percentage, calculated using data reported by the carrier as prescribed under regulations promulgated by the commissioner.

SECTION 23. Subsection (a) of section 3 of said chapter 176J, as so appearing, is hereby amended by striking out clause (2) and inserting in place thereof the following clause:-

(2) A carrier may establish age rate adjustment factors that apply to both eligible individuals and eligible small groups; provided, however, that when a carrier develops such age rate adjustment factor for different ranges of ages, the carrier shall spread the impact of the age rate adjustment factor across the ages in each range to smooth the overall impact of applying such factors.

SECTION 24. Said section 3 of said chapter 176J, as so appearing, is hereby further amended by adding the following 2 subsections:-

(f) The commissioner may conduct an examination of the rating factors used in the small group health insurance market in order to identify whether any expenses or factors inappropriately increase the cost in relation to the risks of the affected small group. The commissioner may adopt changes to the small group regulation each July 1 for rates effective each subsequent January 1 to modify the derivation of group base premium rates or of any factor used to develop individual group premiums.

(g) For small group base rate factors applied between October 1, 2010 and June 30, 2012, a carrier must limit the effect of the application of any single or combination of rate adjustment factors identified in paragraphs (2) to (6), inclusive, of subsection (a) used in the calculation of an individual’s or small group’s premium so that the final annual premium charged to an individual or small group does not increase by more than an amount established annually by the commissioner by regulation.

SECTION 25. Subsection (a) of section 4 of said chapter 176J, as so appearing, is hereby amended by striking out paragraphs (2) to (4), inclusive, and inserting in place thereof the following 3 paragraphs:-

(2) A carrier shall enroll eligible individuals and eligible persons, as defined in section 2741 of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. section 300gg-41(b), into a health plan if such individuals or persons request coverage within 63 days of termination of prior creditable coverage. Coverage shall become effective within 30 days of the date of application, subject to reasonable verification of eligibility.

(3) A carrier shall enroll an eligible individual who does not meet the requirements of paragraph (2) into a health benefit plan during the mandatory biannual open enrollment period for eligible individuals and the eligible dependents of those individuals. Each year, the first open enrollment period shall begin on January 1 and end on February 15. The second open enrollment period shall begin on July 1 and end on August 15. All coverage shall become effective on the first day of the month following enrollment. The commissioner shall promulgate regulations for the open enrollment periods permissible under this section. With respect to Trade Act/Health Coverage Tax Credit Eligible Persons, a carrier may impose a pre-existing condition exclusion or waiting period of no more that 6 months following the individual's effective date of coverage if the Trade Act/Health Coverage Tax Credit Eligible Person has had less than 3 months of continuous health coverage before becoming eligible for the health coverage tax credit; or a break in coverage of over 62 days immediately before the date of application for enrollment into the qualified health plan.

(4) No policy may require a waiting period if the eligible individual has not had creditable coverage for the 18 months prior to the effective date of coverage. Notwithstanding paragraph (3), an eligible individual who does not meet the requirements of paragraph (2) may seek an enrollment waiver to permit enrollment not during a mandatory open enrollment period. Enrollment waivers shall be administered and granted by the office of patient protection established by section 217 of chapter 111.

SECTION 26. Said subsection (a) of said section 4 of said chapter 176J is hereby further amended by striking out paragraph (3), as appearing in section 25, and inserting in place thereof the following paragraph:-

(3) A carrier shall enroll an eligible individual who does not meet the requirements of paragraph (2) into a health benefit plan during the mandatory annual open enrollment period for eligible individuals and their dependents. Each year, the open enrollment period shall begin on July 1 and end on August 15. A carrier shall only enroll an eligible individual who does not meet the requirements of paragraph (2) into a health benefit plan during the open enrollment period. All coverage shall become effective on the first day of the month following enrollment. The commissioner shall promulgate regulations for the open enrollment period permissible under this section. With respect to Trade Act/Health Coverage Tax Credit Eligible

Persons, a carrier may impose a pre-existing condition exclusion or waiting period of no more that 6 months following the individual's effective date of coverage if the Trade Act/Health Coverage Tax Credit Eligible Person has had less than 3 months of continuous health coverage before becoming eligible for the health care tax credit; or a break in coverage of over 62 days immediately before the date of application for enrollment into the qualified health plan.

SECTION 27. Subsection (b) of said section 4 of said chapter 176J, as appearing in the 2008 Official Edition, is hereby amended by striking out clause (1) and inserting in place thereof the following clause:

(1) Notwithstanding any other provision in this section, a carrier may deny an eligible individual or eligible small group enrollment in a health benefit plan if the carrier certifies to the commissioner that the carrier intends to discontinue selling that health benefit plan to new eligible individuals or eligible small businesses. A health benefit plan closed to new members may be cancelled and discontinued to all members upon the approval of the division of insurance when such plan has been closed to enrollment for new individuals and small groups and the carrier has complied with the requirements of 42 U.S.C. section 300gg-12; provided that cancellation of the plan shall be effective on the individual or small group's next enrollment anniversary after such cancellation is approved by the division of insurance. The commissioner may promulgate regulations prohibiting a carrier from using this paragraph to circumvent the intent of this chapter.

SECTION 28. Said chapter 176J is hereby amended by striking out section 6 and inserting in place thereof the following section:-

Section 6. (a) Notwithstanding any general or special law to the contrary, the commissioner may approve health insurance policies submitted to the division of insurance for the purpose of being provided to eligible individuals or eligible small businesses. These health insurance policies shall be subject to this chapter and may include networks that differ from those of a health plan's overall network. The commissioner shall adopt regulations regarding eligibility criteria. These eligibility criteria shall require that health insurance policies that exclude mandated benefits shall only be offered to small businesses which did not provide health insurance to its employees as of April 1, 1992. These eligibility criteria shall also provide that small businesses shall not have any health insurance policies that exclude mandated benefits for more than a 5-year period.

(b) Notwithstanding any general or special law to the contrary, the commissioner shall require carriers offering health benefit plans to eligible small businesses and eligible individuals to submit information as required by the commissioner, including, but not limited to:

(i) underwriting, auditing, actuarial, financial analysis, treasury and investment expenses;

(ii) marketing and sales expenses, including, but not limited to, advertising, member relations, member enrollment and all expenses associated with producers, brokers and benefit consultants;

(iii) claims operations expenses, including, but not limited to, adjudication, appeals, settlements and expenses associated with paying claims;

(iv) medical administration expenses, including, but not limited to, disease management, utilization review and medical management;

(v) network operations expenses, including, but not limited to, contracting, hospital and physician relations and medical policy procedures;

(vi) charitable expenses, including, but not limited to, contributions to tax-exempt foundations and community benefits;

(vii) state premium taxes;

(viii) board, bureau and association fees;

(ix) depreciation; and

(x) miscellaneous expenses described in detail by expense, including any expense not included in clauses (i) to (ix), inclusive.

(c) Notwithstanding any general or special law to the contrary, the commissioner may require carriers offering small group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or 176G, to file all changes to small group product base rates and to small group rating factors at least 90 days before their proposed effective date. The commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate or unreasonable in relation to the benefits charged. The commissioner shall disapprove any change to small group rating factors that is discriminatory or not actuarially sound. Rate filing materials submitted for review by the division shall be deemed confidential and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter 4. The commissioner shall adopt regulations to carry out this section.

(d) For small group base rate changes filed to be effective any time in the period between October 1, 2010 and June 30, 2012, inclusive, if a carrier files for an increase in a small group product's base rate over the prior year's base rate by an amount that is more than 150 per cent of the prior calendar year's percentage increase in the consumer price index for medical care services, as identified by the division of health care finance and policy, or if a carrier files a base rate whose administrative expense loading component increases by more than the most recent calendar year's percentage increase in the employment cost index for the private industry health care and social assistance industry group, as reported by the United States

Bureau of Labor Statistics or if a carrier files an initial base rate request that is greater than the average base rate for actuarially equivalent policies offered by other small group carriers by more than 150 per cent of the prior calendar year's base premium rate, such carrier's rate, in addition to being subject to all other provisions of this chapter, shall be presumptively disapproved as excessive by the commissioner as set forth in this subsection.

If a proposed base rate change has been presumptively disapproved:

(1) A carrier shall communicate to all employers and individuals covered under a small group product that the proposed increase has been presumptively disapproved and is subject to a hearing at the division of insurance.

(2) The commissioner shall conduct a public hearing and shall advertise it in newspapers in Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford and Lowell, or shall notify such newspapers of the hearing.

The commissioner shall adopt regulations to specify the scheduling of the hearings required pursuant to this subsection.

SECTION 29. Said chapter 176J is hereby amended by adding the following section:-

Section 11. (a) A carrier that offers a health benefit plan that: (i) provides or arranges for the delivery of health care services through a closed network of health care providers; and (ii) as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals, shall offer to all eligible individuals and small businesses at least one plan with either a reduced or selective network of providers. The base premium for the reduced or selective network, or any tiered network plan shall be at least 20 per cent lower than the base premium of the carrier's most actuarially similar plan with the carrier's non-selective or non-tiered network of providers.

(b) A tiered network plan shall only include variations on member cost-sharing between provider tiers, which are reasonable in relation to the premium charged, as long as the carrier provides adequate access to covered services at lower patient cost sharing levels.

(c) The commissioner shall determine network adequacy for a tiered network plan based on the availability of sufficient network providers in the carrier's overall tiered network plan.

(d) The commissioner shall determine network adequacy for a select network plan based on the availability of sufficient network providers in the carrier's select network of providers.

(e) In determining network adequacy under this section the commissioner may consider factors including: the location of providers participating in the plan; employers or members that enroll in the plan; the range of services provided by providers in the plan; and any plan benefits that recognize and provide for extraordinary medical needs of members that may not be adequately dealt with by the providers within the plan network.

(f) The division of insurance shall report annually on utilization trends of eligible employers and eligible individuals enrolled in plans offered under this section The report shall include the number of members enrolled by plan type, de-identified aggregate demographic, and geographic information on all members and the average direct premium claims incurred for selective and tiered network plans compared to non-selective and non-tiered plans.

SECTION 30. Chapter 176J is hereby amended by inserting after section 11, inserting by section 29 of this act, the following section:-

Section 12. (a) There shall be a small group wellness incentive program to expand the prevalence of employee wellness initiatives by small businesses. The program shall be administered by the department of public health. The program shall provide subsidies and technical assistance for eligible small groups to implement evidence-based employee health and wellness programs to improve employee health, decrease employer health costs and increase productivity.

(b) An eligible small group shall be qualified to participate in the program if:-

(1) the eligible small group is eligible for federal health care tax credits under the federal Patient Protection and Affordable Care Act;

(2) the eligible small group offers an evidence-based, employee wellness program that meets certain minimum criteria, as determined by the department of public health; and

(3) the eligible small group meets certain minimum employee participation requirements in the qualified wellness program, as determined by the department of public health, in collaboration with the division of insurance.

(c) For eligible small groups participating in the program, the department of public health shall provide an annual subsidy not to exceed 5 per cent of eligible employer health care costs as calculated by the employer for credit by the federal government under the Patient Protection and Affordable Care Act. If the commissioner determines that funds are insufficient to meet the projected costs of enrolling new eligible employers, the director shall impose a cap on enrollment in the program.

(d) The department of public health shall provide technical assistance, including grant-writing assistance, to participating eligible small groups in order to maximize federal grant funding provided under the federal Patient Protection and Affordable Care Act for the establishment of wellness initiatives by small employers.

(e) The department of public health shall seek to ensure that all necessary applications and filings coordinate with, and conform to, appropriate federal guidelines in order to minimize administrative burden on participating small groups.

(f) The department of public health shall report annually to the joint committee on community development and small business, the joint committee on health care financing and the house and senate committees on ways and means on the enrollment in the small business wellness incentive program and evaluate the impact of the program on expanding wellness initiatives for small groups.

SECTION 31. Section 2 of chapter 176M of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting after the word 'renewal', in lines 28 and 39, in each instance, the following words:- , including renewal through the connector.

SECTION 32. Section 3 of said Chapter 176M, as so appearing, is hereby amended by striking out subsection (d) and inserting in place thereof the following subsection:-

(d) As of August 1, 2010, a carrier shall no longer offer, sell or deliver a health plan to a person to whom it does not have such an obligation under an individual policy, contract or agreement with an employer or through a trust or association; provided, however, that a closed guaranteed issue plan or a closed health plan shall be subject to all the other requirements of this chapter. A carrier shall be obligated to renew a closed guarantee issue health plan and a closed plan. A carrier may discontinue a closed guarantee issue health plan or a closed plan under regulations promulgated by the commissioner.

SECTION 33. Section 2 of chapter 176O of the General Laws, as so appearing, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) In establishing the minimum standards, the bureau shall consult and use, where appropriate, standards established by national accreditation organizations. Notwithstanding the foregoing, the bureau shall not be bound by the standards established by such organizations, but wherever the bureau promulgates standards different from said national standards, it shall: (1) be subject to chapter 30A; (2) state the reason for such variation; and (3) take into consideration any projected compliance costs for such variation. In order to reduce health care costs and improve access to health care services, the bureau shall establish by regulation as a condition of accreditation that carriers use uniform standards and methodologies for credentialing of providers, including any health care provider type licensed under chapter 112 that

provides identical services. The division shall, before adopting regulations under this section, consult with the division of health care finance and policy, the department of public health, the group insurance commission, the Centers for Medicare and Medicaid Services and each carrier. Accreditation by the bureau shall be valid for a period of 24 months.

SECTION 34. Chapter 176O is hereby amended by inserting after section 5 the following section:-

Section 5A. (a) A contract or agreement between a carrier and a health care provider, including a hospital, physician group practice or imagining service, entered or renewed on or after January 1, 2011, shall adhere to the following:

(1) A carrier with a contract for payment between the carrier and a health care provider containing a rate, adjusted for volume and acuity, greater than or equal to 10 per cent above the carrier's statewide adjusted average in the previous year beginning October 1 through September 30 shall not increase rates to be paid under that contract beyond the prior year's existing rate.

(2) A carrier with a contract for payment between the carrier and a health care provider containing a rate, adjusted for volume and acuity, greater than zero per cent but lower than 10 per cent above the carrier's statewide adjusted average in the previous year beginning October 1 through September 30 shall not increase rates to be paid under that contract by a percentage greater than the 12 month projected change of the United States city average Consumer Price Index for Medical Care Services for the following year.

(3) A carrier with a contract for payment between the carrier and a health care provider containing a rate, adjusted for volume and acuity, between zero per cent and 10 per cent below the carrier's statewide adjusted average in the previous year beginning October 1 through September 30 shall increase rates to be paid under that contract by a percentage greater than the 12 month projected change of the United States city average Consumer Price Index for Medical Care Services for the following year. These contracts shal not increase by a percentage greater than the 12 month projected change of the Consumer Price Index for Medical Care Services for the New England region for the following year.

(4) A carrier with a contract for payment between the carrier and health care provider containing a rate, adjusted for volume and acuity, greater than 10 per cent below the carrier's statewide adjusted average in the previous year beginning October 1 through September 30 shall increase rates to be paid under that contract by a percentage more than the twelve month projected change of the Consumer Price Index for Medical Care Services for the New England region for the following year.

(b) Notwithstanding subsection (a) a carrier shall not enter or renew a contract or agreement on or after January 1, 2011 with a health care provider, including a hospital, physician group practice, or imaging service, under which the carrier agrees to pay the health care provider a rate that is greater than 15 per

cent above or greater than 15 per cent below the carrier's statewide adjusted average rate, as defined by the division of health care finance and policy.

The division of insurance, in consultation with the division of health care finance and policy, may by regulation establish rate factors based on statistically sound analysis of the differences in the cost of providing health care services for different rate factor categories of health care provider, including, but not limited to, disproportionate share status, specialty, academic status and geographic location. A carrier may enter into or renew a contract on or after January 1, 2011 under which the carrier agrees to pay the health care provider a rate that applies an applicable rate factor established under this section; provided, however, that the resulting rate shall not be greater than 15 per cent above or greater than 15 per cent below the carrier's statewide adjusted average for all health care providers, regardless of whether the rate factor applies to the carrier or not. If a carrier chooses to apply a rate factor established by the commissioner, the carrier shall apply that rate factor consistently to every health care provider within that rate factor category, as determined by the commissioner. A carrier may not apply a rate factor established pursuant to this section to any health care provider that has not entered, renewed or renegotiated its contract to provide services with the carrier between August 1, 2010 and January 1, 2013.

(c) All contracts between a carrier and provider as defined in this section shall be filed with the division of health care finance and policy. The division may specify, by regulation, categories of information which shall be furnished under an assurance of confidentiality to the provider. The division may review all contracts and shall refer any contracts deemed non-compliant to the attorney general.

(d) The division of insurance shall promulgate such regulations as may be necessary to ensure compliance with this section. The division of health care finance and policy shall publish carrier and aggregate statewide adjusted averages, rate factors and applicable consumer price index projections on an annual basis.

(e) Annually, on April 1, carriers shall submit an annual report to the division of health care finance and policy and to the division of insurance that identify all savings from reductions or mitigations in the growth of provider prices for the prior calendar year. The noted savings shall be certified by an actuary independent of the carrier. The division of health care finance and policy shall assess carriers 50 percent of the savings identified in these reports to deposit in the Disproportionate Share Hospital Trust Fund, established in section 35MM of chapter 10, and shall distribute the proceeds of this fund annually to those hospitals meeting the definition of a disproportionate share hospital, as defined in section 1 of 118G, based on the hospital's prior year share of uncompensated care in the commonwealth. The division of health care finance and policy shall promulgate such regulations as may be necessary to ensure compliance with this subsection.

(f) Fifty per cent of the savings identified subsection (e) shall be incorporated as savings in premiums charged to health plan members.

(g) Not later than January 2011, the division of insurance, in consultation with the executive office of health and human services, shall determine the formula for carriers to use in complying with the requirements of this section. The division shall analyze the differences between a carrier's median, weighted average or un-weighted average and shall promulgate regulations requiring the use of either the median, weighted average or un-weighted average as the single standard formula across all carriers. The division in promulgating these regulations shall ensure that the standard formula used achieves the combined goals of maximizing reduction in premiums and reducing the disparities in what the highest and lowest reimbursed providers are paid.

SECTION 35. Section 5A of said chapter 176O is hereby repealed.

SECTION 36. Said chapter 176O of the General Laws is hereby further amended by inserting, after section 9, the following section:-

Section 9A. A carrier shall not enter into an agreement or contract with a health care provider if the agreement or contract contains a provision that:

(a) (i) limits the ability of the carrier to introduce or modify a select network plan or tiered network plan by granting the health care provider a guaranteed right of participation; (ii) requires the carrier to place all members of a provider group, whether local practice groups or facilities, in the same tier of a tiered network plan; (iii) requires the carrier to include all members of a provider group, whether local practice groups or facilities, in a select network plan on an all-or-nothing basis; or (iv) requires a provider to participate in a new select network or tiered network plan that the carrier introduces without granting the provider the right to opt-out of the new plan at least 60 days before the new plan is submitted to the commissioner for approval;

(b) requires or permits the carrier or the health care provider to alter or terminate a contract or agreement, in whole or in part, to affect parity with an agreement or contract with other carriers or health care providers or based on a decision to introduce or modify a select network plan or tiered network plan; or

(c) requires or permits the carrier to make any form of supplemental payment unless each supplemental payment is publicly disclosed to the commissioner as a condition of accreditation, including the amount and purpose of each payment and whether or not each payment is included within the provider’s reported relative prices and health status adjusted total medical expenses under section 6 of chapter 118G.

SECTION 37. Section 1 of chapter 176Q of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by striking out the definition of ‘Eligible individuals’ and inserting in place thereof the following definition:-

‘Eligible individuals’, an individual who is a resident of the commonwealth not seeking individual coverage to replace an employer sponsored health plan for which the individual is eligible and which provides coverage that is at least actuarially equivalent to minimum creditable coverage.

SECTION 38. Section 2 of said chapter 176Q, as so appearing, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) There shall be a board, with duties and powers established by this chapter, which shall govern the connector. The connector board shall consist of 11 members: the secretary for administration and finance, or a designee, who shall serve as chairperson; the director of Medicaid or a designee; the commissioner of insurance or a designee; the executive director of the group insurance commission; 4 members appointed by the governor, 1 of whom shall be a member in good standing of the American Academy of Actuaries, 1 of whom shall be a health economist, 1 of whom shall represent the interests of small businesses and 1 of whom shall be a member of the Massachusetts Association of Health Underwriters; and 3 members appointed by the attorney general, 1 of whom shall be an employee health benefits plan specialist, 1 of whom shall be a representative of a health consumer organization and 1 of whom shall be a representative of organized labor. No appointee shall be an employee of any licensed carrier authorized to do business in the commonwealth. All appointments shall serve a term of 3 years, but a person appointed to fill a vacancy shall serve only for the unexpired term. An appointed member of the board shall be eligible for reappointment. The board shall annually elect 1 of its members to serve as vice-chairperson.

SECTION 39. Subsection (s) of section 3 of said chapter 176Q, as so appearing, is hereby amended by adding the following words:- ; provided, however, that notwithstanding subsection (d) of section 2, no changes to the regulations defining minimum creditable coverage shall take effect until 90 days after the connector gives notice of the changes to the joint committee on health care finance, the joint committee on public health and the house and senate committees on ways and means.

SECTION 40. Section 5 of said chapter 176Q, as so appearing, is hereby amended by adding the following subsection:-

(e) The connector shall not require a carrier to offer a small group health benefit plan through the connector in order to offer an individual health benefit plan through the connector.

SECTION 41. Section 8 of said chapter 176Q, as so appearing, is hereby amended by adding the following sentence: -

The connector shall not utilize any of the data received from the department of revenue for any solicitations or advertising.

SECTION 42. Notwithstanding any general or special law to the contrary, the commissioner of the division of insurance shall file with the joint committee on health care financing and the house and senate committees on ways and means a copy of any state applications requesting funding under the federal Patient Protection and Affordable Care Act. The commissioner shall inform the joint committee on health care financing and the house and senate committees on ways and means in writing of the amount of funds to be allocated as soon as the commissioner receives notification from the federal government.

SECTION 43. Notwithstanding any general or special law to the contrary, the division of insurance, in consultation with the division of health care finance and policy, shall promulgate regulations on or before January 1, 2011 to establish a uniform methodology for calculating and reporting by carriers for the medical loss ratios of health benefit plans under section 6 of chapter 176J and section 6 of chapter 118G of the General Laws. The uniform methodology for calculating and reporting medical loss ratios shall, at a minimum, specify a uniform method for determining whether and to what extent an expenditure shall be considered a medical claims expenditure or an administrative costs expenditure, which shall include, but not be limited to, a determination of which of these classes of expenditures the following expenses fall into: (i) financial administration expenses; (ii) marketing and sales expenses; (iii) distribution expenses; (iv) claims operations expenses; (v) medical administration expenses, such as disease management, utilization review and medical management activities; (vi) network operation expenses; (vii) charitable expenses; (viii) board, bureau or association fees; (ix) state and federal tax expenses, including assessments; (x) payroll expenses; and (xi) other miscellaneous expenses not included in 1 of the previous categories. The methodology shall conform with applicable federal statutes and regulations to the maximum extent possible. The division shall, before adopting regulations under this section, consult with: the group insurance commission; the Centers for Medicare and Medicaid Services; the national association of insurance commissioners; the attorney general; representatives from the Massachusetts Association of Health Plans; the Massachusetts Medical Society Alliance, Inc.; the Massachusetts Hospital Association, Inc.; Health Care for All, Inc.; the Blue Cross and Blue Shield of Massachusetts; the Massachusetts Health Information Management Association; the Massachusetts Health Data Consortium; a representative from a small business association; and a representative from a health care consumer group.

SECTION 44. Notwithstanding any special or general law to the contrary, the division of health care finance and policy, in consultation with the division of insurance, shall promulgate regulations on or before January 1, 2011 to establish a uniform methodology for calculating and reporting the health status adjusted total medical expenses, under section 6 of chapter 118G of the General Laws. The uniform methodology shall apply to a uniform list of provider groups and their constituent local practice groups

and for each zip code in the commonwealth. The uniform methodology for calculating and reporting total medical expenses under this section shall, at a minimum: (i) specify a uniform method for calculating total medical expenses based on allowed claims for all categories of medical expenses, including, but not limited to, acute inpatient, hospital outpatient, sub-acute such as skilled nursing and rehabilitation, professional, pharmacy, mental/behavioral health and substance abuse, home health, durable medical equipment, laboratory, diagnostic imaging and alternative care such as chiropractic and acupuncture claims, incurred under all fully-insured and self-insured plans; (ii) specify a uniform method for including in the calculation all non-claims related payments to providers, including supplemental payments of any type, such as pay-for-performance, infrastructure payments, grants, surplus payments, lump sum settlements, signing bonuses and government payer shortfall payments, infrastructure, medical director and health information technology payments; (iii) specify a uniform method for adjusting total medical expenses by health status; (iv) designate the minimum patient membership in a local practice group for individual reporting of total medical expenses by local practice group; (v) specify a uniform method for reporting total medical expenses in aggregate for all local practice groups that fall below the minimum patient membership; (vi) specify a uniform method for reporting total medical expenses by zip code separately for patient members whose plans require them to select a primary care provider and patient members whose plans do not require them to select a primary care provider; (vii) designate and annually update the comprehensive list of provider groups and local practice groups and zip codes for which payers shall report total medical expenses; and (viii) specify a uniform format for reporting that includes the raw and adjusted health status score and patient membership for each local practice group and zip code. The division shall from time to time require payers to submit the underlying data used in their calculation of total medical expenses for audit.

SECTION 45. Notwithstanding any general or special law to the contrary, the division of health care finance and policy, in consultation with the division of insurance, shall promulgate regulations on or before January 1, 2011 to establish uniform methodology for calculating and reporting relative prices paid to hospitals, physician groups, other health care providers licensed under chapter 112 of the General Laws and freestanding surgical centers by each private and public health care payer under section 6 of chapter 118G of the General Laws. The uniform methodology for calculating and reporting relative prices under this section shall, at a minimum: (i) specify a method for basing the calculation on a uniform mix of products and services by payer that is case mix neutral; (ii) specify a uniform method for including in the calculation all non-claims related payments to providers, including supplemental payments of any type, such pay-for-performance, infrastructure payments, grants, surplus payments, lump sum settlements, signing bonuses and government payer shortfall payments; (iii) permit reporting of relative price in the aggregate for all physician groups whose price equals the payer’s standard fee schedule rates; and (vi) designate and annually update the comprehensive list of physician groups for which payers shall report relative prices.

SECTION 46. Notwithstanding any general or special law to the contrary, the division of health care finance and policy, in consultation with the division of insurance, shall promulgate regulations on or before January 1, 2011 to establish uniform methodology for calculating and reporting inpatient and outpatient costs, including direct and indirect costs, for all hospitals under section 6 of chapter 118G of the General Laws. The division shall, as necessary and appropriate, promulgate regulations or amendments to its existing regulations to require hospitals to report cost and cost trend information in a uniform manner including, but not limited to, uniform methodologies for reporting the cost and cost trend for categories of direct labor, debt service, depreciation, advertising and marketing, bad debt, stop-loss insurance, malpractice insurance, health information technology, medical management, development, fundraising, research, academic costs, charitable contributions and operating margins for all commercial business and for all state and federal government business, including but not limited to Medicaid, Medicare, insurance through the group insurance commission and CHAMPUS. The division shall, before adopting regulations under this section, consult with the group insurance commission, the Centers for Medicare and Medicaid Services, the attorney general and representatives from the Massachusetts Hospital Association, the Massachusetts Medical Society, the Massachusetts Association of Health Plans, the Blue Cross and Blue Shield of Massachusetts, the Massachusetts Health Information Management Association and the Massachusetts Health Data Consortium.

SECTION 47. The department of public health shall promulgate regulations under section 25P of chapter 111 of the General Laws by December 31, 2010 requiring the uniform reporting of a standard set of health care quality measures for each health care provider facility, medical group or provider group in the commonwealth hereinafter referred to as the 'standard quality measure set.'

The department of public health shall convene a statewide advisory committee which shall recommend to the department by November 1, 2010 the standard quality measure set. The statewide advisory committee shall consist of the commissioner of health care finance and policy or the commissioner's designee, who shall serve as the chair; and not more than 8 members, including the executive director of the group insurance commission and the Medicaid director, or the directors designees; and not more than 6 representatives of organizations to be appointed by the governor including at least 1 representative from an acute care hospital or hospital association, 1 representative from a provider group or association, 1 representative from a medical group or association, 1 representative from a private health plan or health plan association, 1 representative from an employer association and 1 representative from a health care consumer group.

In developing its recommendation of the standard quality measure set, the advisory committee shall, after consulting with state and national organizations that monitor and develop quality and safety measures, select from existing quality measures and shall not select quality measures that are still in development or develop its own quality measures. The committee shall annually recommend to the department of public

health any updates to the standard quality measure set by November 1. For its recommendation beginning in 2011, the committee may solicit for consideration and recommend other nationally recognized quality measures not yet developed or in use as of November 1, 2010, including recommendations from medical or provider specialty groups as to appropriate quality measures for that group's specialty. At a minimum, the standard quality measure set shall consist of the following quality measures: (i) the Centers for Medicare and Medicaid Services hospital process measures for acute myocardial infarction, congestive heart failure, pneumonia and surgical infection prevention; (ii) the Hospital Consumer Assessment of Healthcare Providers and Systems survey; (iii) the Healthcare Effectiveness Data and Information Set reported as individual measures and as a weighted aggregate of the individual measures by medical or provider group; and (iv) the Ambulatory Care Experiences Survey.

SECTION 48. Notwithstanding any general or special law to the contrary, eligible individuals as defined in chapter 176J of the General Laws with existing coverage issued under said chapter 176J that will expire after the end of open enrollment in 2010 established under section 4 of said chapter 176J may renew coverage on the date that the eligible individual's coverage expires for a term of less than 1 year until the beginning of open enrollment period in 2011.

SECTION 49. Notwithstanding any general or special law to the contrary, the secretary of health and human services shall convene an administrative simplification working group consisting of the following members: the undersecretary of consumer affairs and business regulation or the undersecretary's designee, the commissioner of health care finance and policy or the commissioner's designee, the commissioner of public health or the commissioner's designee, the commissioner of insurance or the commissioner's designee, the commissioner of revenue or the commissioner's designee, the director of the office of Medicaid or the director's designee, the attorney general or the attorney general's designee, the inspector general or the inspector general's designee, a representative of the Massachusetts Health Data Consortium, a representative of the Health Care Quality and Cost Council, a representative of the Massachusetts Hospital Association, Inc., a representative of Blue Cross Blue Shield of Massachusetts, a representative of the Massachusetts Association of Health Plans, a representative of the Massachusetts Medical Society and the executive director of the commonwealth health connector authority or the executive director's designee. The group shall identify ways to streamline state created or mandated administrative requirements in health care, including ways to reduce health care reporting requirements through maximizing the use of a single all-payer database, as administered by the division of health care finance and policy. The group shall hold its first meeting not later than January 1, 2011 and shall issue a report on or before April 1, 2011. The report shall include specific steps to be taken by each agency and the agencies collectively to reduce administrative and filing requirements on health carriers and health care providers, which shall include, but not be limited to, an interagency agreement to use where

necessary, the all-payer claims database, and to streamline and coordinate requests for all other data from health care providers and health plans in the commonwealth.

SECTION 50. Notwithstanding any general or special law to the contrary, there shall be a special commission to study the impact of reducing the number of health benefit plans that a health care payer may maintain and offer to individuals and employers. The commission shall consist of 13 members including: the commissioner of insurance, who shall serve as chair; the executive director of the commonwealth health insurance connector; and a representative from: the Massachusetts Hospital Association, the Massachusetts Medicaid Society, the Massachusetts Association of Health Plans, the Blue Cross and Blue Shield of Massachusetts, the Massachusetts Health Information Management Association, the Massachusetts Health Data Consortium, a MassHealth contracted managed care organization, Associated Industries of Massachusetts, the Massachusetts chapter of the National Federation of Independent Business and an association of health care providers licensed under chapter 112 of the General Laws who is not a medical doctor. In conducting its analysis, the commission shall examine:

(i) the administrative costs associated with paying claims and submitting claims for multiple health benefit plans on health care payers and providers;

(ii) the costs associated with reducing the number of health benefit plans on consumer and employer choice;

(iii) the impact of limiting the number of health benefit plans on competition between and among insurance payers, including but not limited to, tiered products, limited network products and products with a range of cost sharing options; and

(iv) the potential for disruption to the market resulting from closing a health care payer's existing health benefit plans.

The special commission shall convene not later than October 1, 2010 and shall submit a report to the clerks of the house and senate not later than December 31, 2010.

SECTION 51. Notwithstanding any special or general law to the contrary, in implementing this act, the executive office of health and human services, the department of public health, the division of health care finance and policy, the division of insurance, the group insurance commission and any other relevant governmental entities or commissions may consider the special needs of children and of pediatric patients. In developing or utilizing data standards, quality measurement systems, wellness initiatives or making comparisons of costs and prices, policymakers shall consider the special needs of children and of

pediatric patients and may require that comparative data and reports segregate pediatric patients and providers from adult patients and providers.

SECTION 52. Notwithstanding any general or special law to the contrary, the division of insurance shall conduct a study to ensure that the carrier reporting deadlines included in subsections (b) and (c) of section 6 of chapter 176J of the General Laws are of the appropriate duration to enable carriers to collect sufficient information with which to ensure the accuracy of proposed plan changes. If the division determines that a reporting date of 90 days prior to the effective date of plan changes is inappropriate, the division shall determine the appropriate length of time for carriers to report plan changes to the division of insurance and the attorney general and shall make such recommendation to the general court. The study shall be completed by July 31, 2011 and filed with the clerks of the house of representative and senate, the chairs of the joint committee on health care financing and the chairs of the house and senate committee on ways and means.

SECTION 53. There shall be a special commission to identify the capital needs of the community hospital sector with regard to use of technology and adequacy of facilities, the ability of the sector to meet the health care needs of the general population in the next decade and potential sources of capital to meet those needs. The commission shall also evaluate the role of public programs, payments and regulations in supporting capital accumulation and make recommendations to advance the ability of the community hospital sector to meet the expected demand. The commission shall be comprised of the secretary of health and human services or a designee, the commissioner of public health or a designee, the secretary of administration and finance or a designee, a representative of the Massachusetts Council of Community Hospitals, a representative of the Massachusetts Hospital Association, a representative of the Associated Industries of Massachusetts, a representative of the Massachusetts Business Roundtable, the chief executive officer of the Massachusetts Health and Educational Facilities Authority, the chief executive officer of Mass Development, the chairs of the house and senate committees on ways and means, the house and senate chairs of the joint committee on health care financing, a member of the house of representatives who shall be chosen by the minority leader, a member of the senate who shall be chosen by the minority leader, and 3 members to be appointed by the governor, 1 of whom shall be a chief elected local official with a community hospital located in the community, 1 of whom shall be an individual knowledgeable about demographic trends and hospital utilization and 1 of whom shall be an individual knowledgeable about hospital finance and construction.

The commission shall hold hearings and file a report with the clerks of the house and senate not later than December 31, 2011.

SECTION 54. Notwithstanding the provisions of any general or special law to the contrary, the department of public health shall conduct a study of the commonwealth's community hospitals, with a

particular focus on outmigration of patients and related trends, including but not limited to an examination of observed effects and their potential causes with respect to the following:

(1) the impact on individual community hospitals caused by the opening of additional health care services by providers within the primary service areas of such community hospital, in terms of changes in the number and types of procedures performed and changes in revenues;

(2) recruitment and retention of personnel; and

(3) changes in payer mix.

The department shall issue a report summarizing its findings and making recommendations with respect to strengthening community hospitals not later than December 31, 2010, and shall file such report with the joint committee on health care financing.

SECTION 55. (a) Notwithstanding any general or special law to the contrary, there shall be a special commission to study the value of a uniform claims administration system for all payers in the commonwealth.

(b) The commission shall consist of 11 persons as follows: the commissioner of medical assistance or a designee; the commissioner of insurance or a designee; the commissioner of the division of health care finance and policy or a designee; 1 person appointed by the speaker of the house of representatives; 1 person appointed by the senate president; 1 person designated by the Massachusetts Association of Health Plans; 1 person designated by Blue Cross Blue Shield of Massachusetts; 2 persons designated by the Massachusetts Hospital Association, 1 of whom shall represent teaching hospitals and 1 of whom shall represent community hospitals; and 2 persons designated by the Massachusetts Medical Society. In addition, the regional administrator of the Centers for Medicare & Medicaid Services or a designee, and a member of the senior management of a Medicare administrative contractor will be invited to participate in the commission but without vote.

(c) The commission shall adopt rules and establish procedures it considers necessary for the conduct of its business. The commission may expend funds as may be appropriated or made available for its purposes. The division of health care finance and policy shall provide administrative support to the commission. No action of the commission shall be considered official unless approved by a majority vote of the commission.

(d) The commission shall undertake a study of the feasibility of mandating a single claims administration system for all payers in the commonwealth, other than Medicare, and of the potential savings to be derived from doing so. For purposes of this section the term ‘payer’ shall mean both a private health care payer and a public health care payer, as those terms are defined in section 1 chapter

116G of the General Laws. In undertaking its responsibilities under this section, the commission shall (i) determine the feasibility of using a single claims administration system for all payers in the commonwealth, other than Medicare; (ii) analyze the effects of the implementation of section 55 of chapter 118E of the General Laws and of sections 5A and 5B of chapter 176O of the General Laws; (iii) undertake a detailed analysis of the merits and limits of the Medicare claims administration system; (iv) determine what models exist that might constitute the most efficient and effective consolidated claims administration system; (v) identify potential challenges associated with implementation of a single claims administration system for all payers in the commonwealth other than Medicare and also identify proposed solutions for such challenges; (vi) identify the costs being incurred by payers and providers as a result of multiple claims administration systems; (vii) estimate the potential cost savings to the commonwealth if the Medicaid program were to implement a uniform claims administration system based on Medicare's system, using regional Medicare administrative contractors; (viii) estimate the potential cost savings if all private health care payers in the commonwealth implemented a uniform claims administration system based on Medicare's system, using regional Medicare administrative contractors, including for their Medicare advantage programs; and (ix) determine the potential savings and costs associated with creating incentives or requiring ERISA plans, Taft-Hartley plans and other self-funded health benefit plans to use regional Medicare administrative contractors for claims management.

(e) The commission shall hold its first meeting no later than December 1, 2010, and shall file the report of its findings and recommendations, together with recommended legislation, if any, with the clerks of the senate and the house of representatives and with the governor by no later than June 30, 2011.

SECTION 56. In order to facilitate the provision of cost effective health care services, enhance the quality of care and improve the coordination and efficiency of health care services in the commonwealth, the division of health care finance and policy, herein referred to as the division, shall undertake activities intended to foster the adoption by providers and payers in the commonwealth of arrangements by which providers will contract to accept payment on a bundled, rather than a fee-for-service, basis. To promote provider participation in such bundled payment arrangements, the division shall make technical support available to providers and payers, survey or undertake research concerning existing and proposed bundled payment models within the commonwealth and elsewhere and disseminate the results of such research; assess the effects of federal programs intended to promote use of bundled payment arrangements; and identify sources of funding to support providers in designing and implementing bundled payment initiatives. The division shall have as an objective, but not as a requirement, the implementation of pilot bundled payment programs relating to payment for at least 2 acute conditions or procedures commencing by no later than January 1, 2011, under the terms of which inpatient services, as well as certain services provided pre- and post-inpatient stay, will be paid on a bundled payment basis; and the implementation of pilot bundled payment programs relating to payment for at least 2 chronic conditions commencing by no

later than July 1, 2011. The division shall file reports on the efforts it undertakes to provide support for providers and payers to enter into bundled arrangements and on the progress made toward implementing the goals described in the preceding sentence of this section. Such reports shall be filed with the clerks of the senate and the house of representatives and with the governor not later than January 31, 2011, not later than July 29, 2011 and not later than December 30, 2011.

SECTION 57. It shall be the policy of the general court to impose a moratorium on all new mandated health benefit legislation until July 1, 2012. This moratorium shall not apply to any proposed mandated benefit that has been through the division of health care finance and policy process pursuant to section 38C of chapter 3 of the General Laws.

SECTION 58. Sections 1, 4 to 12, inclusive, 14 to 25, inclusive, 27 to 29, inclusive, 32, 34, 36 and 43 to 57, inclusive, shall take effect on August 1, 2010.

SECTION 59. Sections 2, 3, and 38 shall take effect on October 1, 2010.

SECTION 60. Section 13, 31, 36, 39 shall take effect on July 1, 2012.

SECTION 61. Sections 26, 30, 41, and 42 shall take effect on July 1, 2011.

SECTION 62. Section 33 and 40 shall take effect on January 1, 2011

SECTION 63. Section 35 shall take effect on December 31, 2014.”.